No. 89-1044

In The

Supreme Court of the United States

OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., et al.,

Petitioners,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,

Respondent.

On Petition for a Writ of Certiorari To the United States Court of Appeals for The First Circuit

RESPONSE OF BLUE CROSS & BLUE SHIELD OF RHODE ISLAND TO PETITION FOR WRIT OF CERTIORARI

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Was the Court of Appeals correct in ruling that decisions by a health insurer with lawfully acquired monopoly power not to pay higher prices that discriminated against such insurer did not violate Section 2 of the Sherman Act?

2. Was the Court of Appeals correct in ruling that health insurance programs admittedly within a state's generally applicable laws for the regulation of the business of insurance are "regulated by state law" within the meaning of the McCarran-Ferguson Act as construed by this Court in *FTC v. National Casualty Co.*, 357 U.S. 560 (1958)?

3. Does the exception to the McCarran-Ferguson Act antitrust exemption for acts of "coercion" reach all restraints of trade harmful to competition?

4. Does the decision below with respect to petitioners' claim under Rhode Island tort law raise any federal questions warranting review by this Court?

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STATEMENT OF THE CASE

A. The Facts.

In 1939, respondent Blue Cross was founded as a non-profit, charitable, hospital service corporation under Rhode Island law (J.A. 1953). Its business is to purchase health care services from physicians, hospitals, and other health care providers on behalf of its subscribers (J.A.

696), underwriting the cost of these purchases by spreading the risk of health care expenses among its subscriber groups. Blue Cross is the largest health insurer in Rhode Island, although it has suffered a steady decline in its market share in recent years (J.A. 2117).

Blue Cross' activities are regulated under Rhode Island law by the Department of Business Regulation ("DBR"). The DBR controls the prices Blue Cross charges to subscribers to ensure consistency with the public interest (R.I. Gen. Laws § 27-19-6 and § 42-62-12; J.A. 1113-1114). In addition, the DBR's regulations govern the form and substance of all contracts between Blue Cross and its subscribers.

Petitioner Ocean State is a for-profit physician-owned HMO which achieved phenomenal growth in Rhode Island, growing from 1,000 subscribers in early 1984 to nearly 90,000 subscribers by the end of 1986 (J.A. 53, J.A. 89, J.A. 2131). Like Blue Cross, Ocean State contracted with physicians to provide medical care to its subscribers, and then paid its contracted physicians on a fee-for-service basis. Unlike Blue Cross, Ocean State paid physicians only 80% of their allowed fees at the time service was rendered and withheld 20% (J.A. 1243-1244). Ocean State would pay back physicians some, all, or none of the withheld amount after year-end, dependent upon the Plan's profitability.

Ocean State's management had made a conscious decision to keep its premiums low in order to induce enrollment growth and increase market share (J.A. 1603). Ocean State's growth came largely at Blue Cross' expense. In addition, Blue Cross was experiencing serious

financial problems at that time and was forced, with the DBR's approval, to raise its premiums in order to maintain adequate reserves. As it raised its premiums, it lost more enrollees – which, in turn, forced further rate increases.

In the spring of 1986, Ocean State announced that it would not pay back any of the 20% of the fees withheld from its participating physicians for 1985 (J.A. 1949). Since Ocean State's fees approximated Blue Cross', Blue Cross realized that it was paying those physicians who participated in both plans[1] approximately 20% more than they were accepting as payment in full from Ocean State (J.A. 1949-1950). In effect, those physicians were giving Ocean State a 20% discount off the Blue Cross fees (J.A. 1182, J.A. 988).

To compete, Blue Cross adopted a number of new programs using traditional business techniques. First, it initiated a policy called "Prudent Buyer." This was nothing more than a "most favored nations" clause, which provided that Blue Cross would not pay a physician more for a service than that physician was accepting as payment in full from another buyer. Blue Cross did not insist on a price from physicians which was lower than that being paid by Ocean State or any other buyer; it merely wished to stop being the victim of price discrimination (J.A. 1967).

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[1] A physician may participate in more than one health insurance program. Thus, a physician may contract with Blue Cross, with Ocean State, or with both. Petitioners' Appendix ("App.") at 2a-3a; 883 F.2d at 1103.

Accordingly, as part of the Prudent Buyer policy, Blue Cross required its participating physicians to certify that they were not accepting lower fees from other insurers than they were receiving from Blue Cross for the same service. As a result of the Prudent Buyer policy, Blue Cross "achieved significant cost savings." App. 5a; 883 F.2d at 1104. After the implementation of Prudent Buyer, approximately 350 of Ocean State's 1200 physicians resigned, at least in some cases in order to avoid a reduction in their Blue Cross fees (P.E. 204; J.A. 192-194).

Blue Cross' second competitive response was to create its own HMO "look-alike" product, called HealthMate. HealthMate arose from a Blue Cross study which concluded that Blue Cross was losing subscribers to Ocean State because Ocean State's rates and benefit package were more attractive (J.A. 734-736). Moreover, Ocean State was specifically targeting younger and healthier people, who were better health insurance risks, through the use of a "pre-existing condition" clause (J.A. 54-55, J.A. 1166).[2] The result of Ocean State's targeted marketing was a phenomenon known as "adverse selection," in which the HMO insured younger and healthier low-risk subscribers (allowing lower premiums), while Blue Cross was left with an older and sicker enrollment population (requiring higher premiums to cover the correspondingly greater risk).

With the HealthMate product, Blue Cross simply matched Ocean State's marketing approach and benefit

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[2] A pre-existing condition clause limits coverage for health conditions pre-existing the date of enrollment. Its effectiveness in deterring unhealthy applicants was established without serious opposition at trial.

package (J.A. 716-717). HealthMate was selectively marketed where there was at least a threat of another HMO offering its program to a group (J.A. 521, J.A. 831). It was used when necessary to meet competition (J.A. 831).[3] Due to its own pre-existing condition clause and targeting of younger and healthier subscribers, HealthMate was offered at a price lower than the cost of traditional Blue Cross, although its rate was still higher than the Ocean State rate. App. 39a; 692 F. Supp. at 58; J.A. 94. Contrary to petitioners' suggestion (Petitioners' Brief at 5, 23 n.10), the undisputed evidence at trial was that HealthMate was sold by Blue Cross at a profit (J.A. 1125).

The third new policy adopted by Blue Cross involved "adverse selection" pricing. Because of the adverse selection Blue Cross was experiencing *vis-a-vis* Ocean State and other HMOs (whereby Blue Cross subscribers were older, sicker, and hence, more expensive), the projected health care costs for Blue Cross' standard health insurance were higher in those employer groups that offered an HMO option than in those employer groups that did not. With the approval of the DBR, Blue Cross instituted a pricing plan that took account of this projected difference in health expenses.[4] Under this policy, employers were

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[3] There is nothing improper in selectively meeting competition. *See, Falls City Industries, Inc. v. Vanco Beverage, Inc.*, 460 U.S. 428, 444, 103 S.Ct. 1282, 1293, 75 L.Ed.2d 174, 192 (1983).

[4] Blue Cross studies demonstrated that subscribers transferring from Blue Cross to an HMO that applied a "pre-existing condition" clause (such as Ocean State) utilized, on average, approximately 22% less health benefits than the pre-transfer group population (J.A. 1035-1036). Blue Cross initially adopted

(Continued on following page)

offered three different rates for traditional Blue Cross coverage. The rate was lowest for an employer who offered only traditional Blue Cross, somewhat higher for an employer who offered employees three choices – traditional Blue Cross, a competing HMO, and HealthMate (to counteract adverse selection of Blue Cross), and highest for an employer who offered a competing HMO but who declined to offer HealthMate. All three rates were computed using formulas and factors approved by the DBR (J.A. 1133).

B. Proceedings Below.

Ocean State, together with a certified class of approximately 900 physicians still under contract to provide medical services to both Blue Cross and Ocean State, brought suit against Blue Cross in the United States District Court for the District of Rhode Island. The complaint sought treble damages and injunctive relief based upon alleged violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Later, petitioners were granted leave to amend their complaint to add a state law claim charging Blue Cross with having intentionally interfered with Ocean State's contractual relationships with the class of physicians through implementation of the Prudent Buyer policy (J.A. 2261).

(Continued from previous page)

the adverse selection pricing policy in June, 1986 without approval from the DBR – believing that its DBR approved rating formula was sufficiently broad to permit it. The DBR disagreed and, in October, 1986, ordered Blue Cross to suspend the policy until it obtained specific approval. In November, 1986, the DBR approved Blue Cross' adverse selection rate formula, and Blue Cross resumed its use. See App. 4a n.1; 883 F.2d at 1103 n.1.

The case was tried before the Honorable Chief Judge Boyle and a jury. At the close of petitioners' case-in-chief, the district court directed a verdict in favor of Blue Cross on the Sherman Act Section 1 claims, finding a "total lack of any evidence" in support of such claims. The Sherman Act Section 2 claim and the tort claim were submitted to the jury, which found Blue Cross "guilty" of a violation of Section 2, but expressly found "no damages" to either Ocean State or the class on that claim (J.A. 31). The jury found Blue Cross "guilty" of the state law claim of intentional interference with contractual relations and awarded compensatory damages to Ocean State in the amount of $947,000 and to the class in the amount of $1,746,437. The jury awarded Ocean State punitive damages in the amount of $250,000.

Blue Cross moved for entry of judgment notwithstanding the verdict, and alternatively for a new trial on the state law count. Ocean State and the class petitioned the court for entry of an injunction and for *additur*. By opinion and order dated July 27, 1988, and July 28, 1988, respectively, the district court granted judgment notwithstanding the verdict and denied petitioners' motion, finding, *inter alia*, that Blue Cross did not misuse its market power in violation of Section 2 of the Sherman Act by implementing the Prudent Buyer policy, by selectively marketing HealthMate, or by its "adverse selection" pricing. App. 67a; 692 F. Supp. at 72. The district court also found, as a matter of Rhode Island law, that Blue Cross did not unjustifiably interfere with Ocean State's contract with the class and that the jury's verdict on that count was against the clear weight of the evidence. App. 70a; 692 F. Supp. at 73. Finally, the district court ruled that

none of the challenged practices was anticompetitive, but rather that they benefited consumers and represented legitimate responses to competitive conditions. In the alternative, the district court granted Blue Cross' motion for a new trial, finding "[a] new trial is required to prevent injustice." App. 70a; 692 F. Supp. at 73.

The Court of Appeals affirmed, finding that the HealthMate and adverse selection policies were exempt from the Sherman Act under the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b). As the court reasoned in an opinion by Chief Judge Campbell, both programs qualified as the "business of insurance": HealthMate is an insurance policy which spreads the risks of policyholders; adverse selection is a pricing policy that inherently involves risk spreading. Both programs directly involve the relationship between the insurer and the insured and were, by definition, limited to entities in the "insurance industry." App. 12a-13a; 883 F.2d at 1107. The Court of Appeals also found (1) that it was "clear that both HealthMate and the adverse selection policy were 'regulated by state law.' " (App. 15a; 883 F.2d at 1108); and (2) that "adverse selection" pricing did not constitute "coercion" within the meaning of the exception to the McCarran-Ferguson exemption, holding that, in any event, Ocean State had waived the coercion argument (App. 16a n.10; 883 F.2d 1109 n.10).

With respect to the Prudent Buyer policy, the Court of Appeals found that Blue Cross' use of a most favored nations clause was not, as a matter of law, violative of Section 2 of the Sherman Act. The court noted that Blue Cross, for purposes of the appeal, did not dispute its monopoly power in a market for health care insurance in

Rhode Island. On the other hand, Ocean State conceded that Blue Cross acquired its historical advantages legitimately. The question, therefore, was whether Blue Cross maintained its lawfully acquired monopoly position through improper means. App. 18a; 883 F.2d at 1110. The court found that Blue Cross' conduct did not go beyond the needs of ordinary business dealings, beyond the ambit of ordinary business skill, and did not unnecessarily exclude competition from the health care insurance market. App. 19a; 883 F.2d at 1110. Relying upon its decision authored by Judge Breyer in *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985), the court noted that Blue Cross – like any purchaser of goods or services – is lawfully entitled to bargain with its providers for the best price it can get (App. 20a; 883 F.2d at 1111), and held that "[t]he antitrust laws do not prevent a purchaser from making such an obviously reasonable and obtainable price bargain with a provider." App. 23a; 883 F.2d at 1112.

SUMMARY OF ARGUMENT

With classic hyperbole, petitioners state that the Court of Appeals has adopted a rule which shields "all exclusionary practices for which a defendant monopolist could proffer any colorable efficiency justification." (Petitioners' Brief at 10). This is manifestly incorrect. The court below said no such thing, holding only that a health insurer with lawfully acquired monopoly power does not violate Section 2 of the Sherman Act when it refuses to pay providers, from whom it purchases health services,

prices higher than those charged by such providers to others.

Blue Cross, notwithstanding its position as the largest health insurer in Rhode Island, was the victim of price discrimination by its physician-suppliers. Thus, this is a fact-specific case involving the unusual circumstance of price discrimination *against* a monopoly. Blue Cross responded, as would any prudent business in a like situation of competitive necessity, by declining to pay more than the price being charged by physicians to its competitor for exactly the same procedures. The Court of Appeals correctly ruled that this competitive response was not an act of monopolization.

Moreover, and most significantly, the theory of non-price predation espoused by petitioners to this Court was never raised in the Court of Appeals until the Petition for Rehearing.

With respect to the antitrust exemption provided by the McCarran-Ferguson Act, the court correctly found that Ocean State had waived any argument that Blue Cross' conduct took the form of coercion within the meaning of the McCarran-Ferguson Act by failing to mention it in its initial brief on appeal. The Court of Appeals also applied long standing precedent of this Court in finding that both HealthMate and the adverse selection policy were regulated by state law.

REASONS FOR DENYING THE WRIT

I. THE THEORY OF NON-PRICE PREDATION WAS NOT RAISED IN THE COURT OF APPEALS UNTIL THE PETITION FOR REHEARING AND IN ANY EVENT HAS NO APPLICABILITY TO THIS UNIQUE SET OF FACTS.

In an unabashed attempt to create an issue worthy of this Court's attention when there is none, petitioners mischaracterize the theory and holding of the Court of Appeals. The court below by no means held (or even suggested) that "any colorable efficiency justification" for a monopolist's conduct (Petitioners' Brief at 10) transforms otherwise illegal exclusionary conduct into lawful conduct. Rather, the decision applied settled principles to a unique set of facts.

Despite its admitted market power in the Rhode Island health insurance market, Blue Cross found itself the victim of price discrimination by its physician-suppliers who were selling their services to a competitor for substantially less than they were charging Blue Cross. Physicians were granting Ocean State a substantial discount despite Blue Cross' position as the largest purchaser of physician services in Rhode Island. This is not a situation normally encountered in business – even in the domain of medical costs which, as Judge Breyer has described it, is "an area of great complexity where more than solely economic values are at stake." *Kartell, supra*, 749 F.2d at 931. Blue Cross' reaction to this discrimination was routine and what any properly motivated competitive

business would do; it adopted a "most favored nations" clause – a common feature in purchase-supply contracts.[5]

Instead of creating a broad rule of general application as petitioners suggest, the Court of Appeals, after reviewing the trial record, held that Blue Cross' policy of insisting upon receiving a supplier's lowest price tended to further competition on the merits, not stifle it. The court also agreed with the district court's view:

> As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.

App. 19a; 883 F.2d at 1110, quoting 692 F. Supp. at 71.

This ineluctably follows from the holding of the First Circuit in *Kartell, supra,* 749 F.2d 922 (1st Cir. 1984), a decision which petitioners admit is correct. (Petitioners' Brief at 19). In fact, the legality of the Prudent Buyer policy rests *a fortiori* upon the holding in *Kartell,* a case where Blue Shield of Massachusetts was held to have legally limited the fees charged by physicians to subscribers; here, Blue Cross is limiting the price that *it* pays to the physicians for services it is purchasing. App. 20a; 883 F.2d at 1111.

The Court of Appeals correctly observed that Section 2 of the Sherman Act does not prohibit vigorous competition on the part of a company with lawfully acquired

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[5] Use of "most favored nations" clauses is common. *See, e.g., E.I. duPont de Nemours & Co. v. Federal Trade Commission,* 729 F.2d 128, 142 (2d Cir. 1984) (vacating an FTC order prohibiting use of "most favored nations" clauses in the sales contracts of gasoline additive manufacturers).

monopoly power. App. 18a; 883 F.2d at 1110. To the contrary, the primary purpose of the antitrust laws is to encourage competition. *See, e.g., Standard Oil Co. v. Federal Trade Commission*, 340 U.S. 231, 248-49, 71 S.Ct. 240, 249-50, 95 L.Ed. 239, 250-51 (1951). Thus, even a monopoly does not violate the Sherman Act simply by competing strenuously with its competition and by getting the rewards. *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 276 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980). A monopoly may lawfully compete, even if that competition results in injury to its competitors. *California Computer Products, Inc. v. IBM Corp.*, 613 F.2d 727, 742 (9th Cir. 1979).

Petitioners' response is that the Court of Appeals should have viewed the Prudent Buyer policy "as a classic instance of 'raising rivals' costs', a form of non-price predation." (Petitioners' Brief at 15). Petitioners, however, did not request a jury charge on "non-price predation" and the issue was not submitted to the jury. Indeed, petitioners took no exception to the Sherman Act Section 2 charge given by the district court to the jury. Rather, petitioners first articulated their theory of "non-price predation" in their Petition for Rehearing, which was denied by the Court of Appeals. Under these circumstances, any such theory has been waived and may not in the first instance be addressed in this Court. *See International Brotherhood of Electrical Workers v. Hechler*, 481 U.S. 851, 862 n.5, 107 S.Ct. 2161, 2179 n.5, 95 L.Ed.2d 791, 803 n.5 (1987); *County of Oneida v. Oneida Indian Nation*, 470 U.S. 226, 245, 105 S.Ct. 1245, 1257, 84 L.Ed.2d 169, 185 (1985); *Kosak v. United States*, 465 U.S. 848, 852 n.7, 104 S.Ct. 1519, 1523 n.7, 79 L.Ed.2d 860, 866 n.7 (1984) (the Court will not consider an argument which was not presented to the Court of Appeals).

Moreover, this theory is novel. There has been no reported district court or court of appeals decision cited by petitioners that explains the theory.[6]

In any event, the record below demonstrated not only that Ocean State did not generally increase physician fees after the implementation of Prudent Buyer, but that it did just the opposite. Ocean State's Chief Executive Officer testified that Ocean State instituted an across-the-board reduction of physician office charges and an across-the-board reduction of physician fees to a median price *after* the announcement of Blue Cross' Prudent Buyer policy (J.A. 191). Moreover, while there was testimony that Ocean State did raise some doctors' fees to keep them happy, Ocean State's Chief Financial Officer testified unequivocally that those fee increases were funded from a pool of money already committed to be paid to physicians and, accordingly, did not cost Ocean State any money (J.A. 1261). In fact, Ocean State's physician expenses as a percentage of its revenues declined significantly after implementation of Blue Cross' Prudent Buyer policy (J.A. 242).

Petitioners' other arguments concerning the Prudent Buyer policy merit no more than summary treatment.

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[6] "Raising rivals' costs" has been proposed by some scholars as a framework for addressing exclusionary vertical restraints under the antitrust laws based upon their economic effect. Krattenmaker & Sallop, *Anti-Competitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209 (1986). This theory expressly rejects this Court's prevailing jurisprudence. 96 Yale L.J. 209, 213. Moreover, even Professors Krattenmaker and Sallop admit that contested cases involving the type of restraint suggested here are "exceedingly rare." 96 Yale L.J. 209, 228.

They argue, for example, that the Court of Appeals erred in not permitting the jury to determine whether Blue Cross' response raised prices to consumers. However, pervasive state regulation of Blue Cross' rates eliminated its ability to control price. There simply was no evidence in the record, even when viewed in the light most favorable to petitioners, from which any reasonable inference could be drawn that the Prudent Buyer policy resulted in increased costs to consumers. To the contrary, the Court of Appeals, through Chief Judge Campbell, found "[a]s a result of the Prudent Buyer policy, Blue Cross achieved significant cost savings." App. 5a; 883 F.2d at 1104.

With respect to the assertion that Blue Cross had monopoly (or, more accurately, monopsony) power in a physicians services' market, Ocean State never raised the issue before the Court of Appeals. The petitioners' claim that Blue Cross had monopoly/monopsony power in a market for the purchase of physician services was not a theory presented to the jury. Further, the undisputed evidence was that Blue Cross' market share in the purchase of physician services in Rhode Island was approximately 20 to 25% – clearly insufficient to control prices or exclude competitors. (J.A. 2087-2089).

Moreover, with respect to the allegation that Blue Cross was a "monopoly broker" (Petitioners' Brief at 18, 20), this too was not raised before the Court of Appeals. The evidence was clear that there were no contractual restrictions preventing physicians from participating in as many health insurance plans as they desired. App. 3a; 883 F.2d at 1103. Theoretically at least, both Ocean State and Blue Cross could have enrolled all of the licensed physicians in Rhode Island as participants.

In short, petitioners' theory of "non-price predation" is not properly before this Court because it has been waived and has no applicability to this unique set of facts.

II. THE DECISION BELOW CONCERNING THE McCARRAN-FERGUSON ACT APPLIES ESTABLISHED PRECEDENT OF THIS COURT.

Petitioners attack the Court of Appeals' ruling concerning exempt conduct under the McCarran-Ferguson Act on two grounds. First, they invite the Court to develop a definition of "coercion" as used in the exception to the exemption. Second, they suggest the Court should revisit the standard it established long ago in interpreting the "regulated by state law" requirement of the McCarran-Ferguson Act. Neither issue warrants review.

The Court of Appeals correctly found that petitioners waived the coercion argument by failing to take exception to it in their initial brief on appeal. Since petitioners failed to argue that Blue Cross' conduct took the form of coercion within the meaning of the McCarran-Ferguson Act, the court ruled that their attempt to resurrect the argument in a reply brief was untimely. App. 16a n.10; 883 F.2d at 1109 n.10.

In any event, even the petitioners recognize the "dearth" of case law in the district and appellate courts interpreting the term "coercion" in the McCarran-Ferguson Act context. (Petitioners' Brief at 24). Petitioners urge this Court to deem an act as coercive, and hence not exempt for purposes of the McCarran-Ferguson Act, whenever economic power is used to force a result that

would not otherwise have been accomplished. Self-evidently, such a broad definition of the exception to the exemption would totally eliminate the exemption itself. "Coercion," by petitioners' definition, would be the equivalent of any restraint of trade – the very thing the Act was designed to exempt from scrutiny.

As for the second argument with respect to the McCarran-Ferguson Act, petitioners concede (Petitioners' Brief at 26) that this Court has ruled that the existence of a general regulatory scheme is sufficient to satisfy the "regulated by state law" requirement of the Act. *FTC v. National Casualty Co.*, 357 U.S. 560, 564-65, 78 S.Ct. 1260, 1262, 2 L.Ed.2d 1540, 1543 (1958). They also acknowledge the lower court teachings which follow *National Casualty Co., supra*. Nevertheless, petitioners urge this Court to change this standard to the decidedly more restrictive regulatory requirement applicable to the state action doctrine. Petitioners' argument that the standards for state action immunity under *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943), should apply to the McCarran-Ferguson Act, lacks any support. Such an interpretation would nullify Congressional intent in adopting the Act, which would have been unnecessary if it were merely duplicative of the generally applicable state action doctrine.

Thirty-two years have elapsed since this Court's pronouncement in *National Casualty Co., supra*. In the meantime, Congress has taken no action to change it. Clearly, rewriting the McCarran-Ferguson Act is a job for Congress, if it is so inclined.

Finally, as an illustration of the problems which petitioners allege could occur as a result of the historical interpretation of "state regulation," they note that Blue Cross began using the adverse selection pricing formula before state approval was obtained. (Petitioners' Brief at 28). However, as the Court of Appeals correctly observed, such a lapse on Blue Cross' part has little bearing on whether the use of the adverse selection pricing was "regulated by state law." It was precisely due to the presence of a comprehensive state regulatory system that the DBR was able to order Blue Cross to suspend its use of adverse selection pricing and prohibit its resumption until after DBR approval was obtained. App. 15a n.8; 883 F.2d at 1109 n.8.

III. THE DECISION BELOW CAN BE AFFIRMED ON ENTIRELY SEPARATE GROUNDS.

Although the Court of Appeals declined to decide the issue, its decision regarding petitioners' Sherman Act Section 2 claims can be upheld on the entirely separate grounds utilized by the district court. The jury found Blue Cross "guilty" of conduct violating Section 2 of the Sherman Act, but affirmatively found "no damages" as a result of that conduct. As Chief Judge Boyle of the district court concluded, this meant that petitioners failed to establish an essential element of their proof. App. 55a; 692 F. Supp. at 66. Under these circumstances, judgment for Blue Cross was mandated. *Association of Western Railways v. Riss & Co.*, 299 F.2d 133, 136 (D.C. Cir. 1962), *cert. denied*, 370 U.S. 916 (1962); cf. *Poulin Corp. v. Chrysler Corp.*, 861 F.2d 5, 7 (1st Cir. 1988).

In *Riss, supra,* defendants were charged with a conspiracy to monopolize and eliminate competition in the transportation of ammunition and explosives for the United States in violation of Sections 1 and 2 of the Sherman Act. Plaintiff sued for treble damages under Section 4 of the Clayton Act. The jury returned general verdicts "for" the plaintiff but responded with the words "$ none" as the "total amount of your verdict." The Court of Appeals correctly interpreted that verdict, which is virtually identical to the verdict in this case, as a jury finding that the alleged conspiracy had not damaged *Riss.* Noting that the "gist" of Section 4 of the Clayton Act is not merely an antitrust violation but "damage to the individual plaintiff resulting proximately from the acts of the defendant which constitute a violation of the law" (*Riss, supra,* 299 F.2d at 135), the finding meant that plaintiff had not proved its claim.

Since the jury's verdict mandated the entry of judgment for Blue Cross in any event, there is no basis for further review of the antitrust claims in this Court.

IV. THE PRUDENT BUYER POLICY WAS A LEGITIMATE COMPETITIVE ACT WHICH CANNOT CONSTITUTE INTENTIONAL INTERFERENCE WITH CONTRACTUAL RELATIONS UNDER RHODE ISLAND LAW.

Finally, petitioners urge this Court to grant certiorari to review the Court of Appeals' affirmation of the district court's analysis of admittedly "independent principles of state tort law" by Chief Judge Boyle. (Petitioners' Brief at 30). This does not raise a federal issue for this Court's consideration.

The tort theory pursued by petitioners was that the Prudent Buyer policy "interfere[d] with existing contractual relationships between plaintiff Ocean State and Class Members" (J.A. 15). However, petitioners concede that the district court correctly instructed the jury under Rhode Island law, which standard the district court then used in rendering its decision. Moreover, as the Court of Appeals noted, "[n]o other relevant tort standards have been called to our attention in the case law or otherwise." App. 27a; 883 F.2d at 1114. That being the case, petitioners cannot now challenge the lower courts' application of Rhode Island state law on this claim.

CONCLUSION

The rulings by two courts, upon reviewing the record, that respondent Blue Cross was entitled to judgment as a matter of law, do not present an important question of federal law unsettled by this Court, or one in conflict with applicable decisions of this Court, or a case otherwise calling for the supervision of the Supreme Court of the United States. Accordingly, the petition should be denied.

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